FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0019836

Facility Name: BUCKINGHAM PAVILION

Address: 2625 WEST TOUHY (Number) CHICAGO (City) 60645 (Zip Code)

County: COOK

Telephone Number: (773) 973-5333 **Fax #** (773) 973-5222

IDPA ID Number: 362771634001

Date of Initial License for Current Owners: 02/01/75

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) JEFFREY K. SINGER, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds NONE

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	247	Skilled (SNF)	247	90,155	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	247	TOTALS	247	90,155	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,126	243	2,121	3,490	8
9	SNF/PED					9
10	ICF	30,053	11,307	413	41,773	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,179	11,550	2,534	45,263	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 50.21%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 2/1/1975

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 37 and days of care provided 1695

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	152,896	26,773	7,243	186,912		186,912		186,912			1
2	Food Purchase		174,981		174,981	(23,871)	151,110	(438)	150,672			2
3	Housekeeping	123,384	16,976		140,360		140,360		140,360			3
4	Laundry	50,215	4,639		54,854		54,854	(3,909)	50,945			4
5	Heat and Other Utilities			132,687	132,687		132,687		132,687			5
6	Maintenance			70,262	70,262		70,262		70,262			6
7	Other (specify):*											7
8	TOTAL General Services	326,495	223,369	210,192	760,056	(23,871)	736,185	(4,347)	731,838			8
	B. Health Care and Programs											
9	Medical Director			7,800	7,800		7,800		7,800			9
10	Nursing and Medical Records	1,279,751	30,385	50,429	1,360,565		1,360,565		1,360,565			10
10a	Therapy	51,489		653	52,142		52,142		52,142			10a
11	Activities	64,209	12,321	152	76,682		76,682		76,682			11
12	Social Services	37,056		4,548	41,604		41,604		41,604			12
13	Nurse Aide Training			12,844	12,844		12,844		12,844			13
14	Program Transportation			1,591	1,591		1,591		1,591			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,432,505	42,706	78,017	1,553,228		1,553,228		1,553,228			16
	C. General Administration											
17	Administrative	52,399		282,602	335,001		335,001		335,001			17
18	Directors Fees											18
19	Professional Services			70,441	70,441	(9,524)	60,917	(500)	60,417			19
20	Dues, Fees, Subscriptions & Promotions			97,598	97,598		97,598	(74,920)	22,678			20
21	Clerical & General Office Expenses	192,906	21,591	18,670	233,167		233,167	(13,282)	219,885			21
22	Employee Benefits & Payroll Taxes			269,921	269,921	23,871	293,792		293,792			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,300	3,300		3,300	195	3,495			24
25	Other Admin. Staff Transportation			1,970	1,970		1,970		1,970			25
26	Insurance-Prop.Liab.Malpractice			173,586	173,586		173,586		173,586			26
27	Other (specify):*											27
28	TOTAL General Administration	245,305	21,591	918,088	1,184,984	14,347	1,199,331	(88,507)	1,110,824			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,004,305	287,666	1,206,297	3,498,268	(9,524)	3,488,744	(92,854)	3,395,890			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number BUCKINGHAM PAVILION #0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			42,558	42,558		42,558	77,798	120,356			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,576	4,576		4,576	(346)	4,230			32
33	Real Estate Taxes			233,046	233,046	9,524	242,570		242,570			33
34	Rent-Facility & Grounds			751,712	751,712		751,712	(751,712)				34
35	Rent-Equipment & Vehicles			7,623	7,623		7,623		7,623			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,039,515	1,039,515	9,524	1,049,039	(674,260)	374,779			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	27,250	203,885	46,888	278,023		278,023		278,023			39
40	Barber and Beauty Shops			15,227	15,227		15,227	(15,227)				40
41	Coffee and Gift Shops			2,827	2,827		2,827		2,827			41
42	Provider Participation Fee			135,233	135,233		135,233		135,233			42
43	Other (specify):*	11,059			11,059		11,059	(11,059)				43
44	**TOTAL Special Cost Centers**	38,309	203,885	200,175	442,369		442,369	(26,286)	416,083			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,042,614	491,551	2,445,987	4,980,152		4,980,152	(793,400)	4,186,752			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(13,006)	30		9
10	Interest and Other Investment Income	(346)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(438)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(25)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(32,359)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(9,285)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(42,518)	20		28
29	Other-Attach Schedule	(34,515)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (132,492)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(660,908)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (660,908)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (793,400)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

BUCKINGHAM PAVILION

ID# 0019836

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	BANK SERVICE CHARGES	$ (18)	20	1
2	BEAUTY SHOP INCOME	(15,227)	40	2
3	LAUNDRY INCOME	(3,909)	4	3
4	2001 SEMINAR	375	24	4
5	OTHER INCOME	(3,997)	21	5
6	NONALLOWABLE LEGAL	(500)	19	6
7	NONALLOWABLE SEMINAR	(180)	24	7
8	MARKETING SALARIES	(11,059)	43	8
9				9
10				10
11				11
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91				91

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(438)											(438)	2
3	Housekeeping													3
4	Laundry	(3,909)											(3,909)	4
5	Heat and Other Utilities													5
6	Maintenance													6
7	Other (specify):*													7
8	**TOTAL General Services**	(4,347)											(4,347)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**													16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(500)											(500)	19
20	Fees, Subscriptions & Promotions	(74,920)											(74,920)	20
21	Clerical & General Office Expenses	(13,282)											(13,282)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	195											195	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*													27
28	**TOTAL General Administration**	(88,507)											(88,507)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(92,854)											(92,854)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(13,006)	90,804										77,798	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(346)											(346)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(751,712)										(751,712)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	**TOTAL Ownership**	(13,352)	(660,908)										(674,260)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops	(15,227)											(15,227)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(11,059)											(11,059)	43
44	**TOTAL Special Cost Centers**	(26,286)											(26,286)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(132,492)	(660,908)										(793,400)	45

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SHELDON STERN	40.00%	NONE		CONCORD PLAZA	CHICAGO	RETIRE COMM
RITA SLATUS	30.00%			PLAZA ON THE LAK	CHICAGO	RETIRE COMM
LEAH KASLOW	30.00%			PLAZA ON THE LAK	CHICAGO	RETIRE COMM

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 703,712	SRL TRUST		$	$ (703,712)	1
2	V	30	DEPRECIATION		SRL TRUST		90,804	90,804	2
3	V								3
4	V	34	RENT	48,000	WAVELAND JOINT VENTURE			(48,000)	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 751,712			$ 90,804	$ * (660,908)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Margaret Stern	Administrator	Administration	0%	None	60	100.00%	Salary	$ 52,399	17-01	1
2	Sheldon Stern	Vice President	Administration	40.00%	None	55	91.66%	Mgmt fees	282,602	17-03	2
3	Serbrana Stern	Relative	Receptionist	0%	None	1	100.00%	Salary	118	21-01	3
4	Rena Stern	Relative	Activities	0%	None	5	100.00%	Salary	2,691	11-01	4
5	Aryeh Stern	Relative	Receptionist	0%	None	1	100.00%	Salary	383	21-01	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 338,193		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

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1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
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12										12
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19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

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1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
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12										12
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16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
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2										2
3										3
4										4
5										5
6										6
7										7
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18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
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12										12
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17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
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6										6
7										7
8										8
9										9
10										10
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13										13
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16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
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4										4
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7										7
8										8
9										9
10										10
11										11
12										12
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17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
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6										6
7										7
8										8
9										9
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16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
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8										8
9										9
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19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
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Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
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15										15
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17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	FIRST INSURANCE FUNDING		X	INSURANCE	$17,710	08/01/00	197,941	53,130			4,576	6
7												7
8												8
9	TOTAL Facility Related				$17,710		$ 197,941	$ 53,130			$ 4,576	9
	B. Non-Facility Related*											
10	See Supplemental Schedule											10
11	Interest Income		X								(346)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (346)	14
15	TOTALS (line 9+line14)						$ 197,941	$ 53,130			$ 4,230	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$	21

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	336,366	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	284,411	2
3. Under or (over) accrual (line 2 minus line 1).	$	(51,955)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	285,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	9,524	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	242,569	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	341,097	8
	1997	393,245	9
	1998	338,639	10
	1999	336,365	11
	2000	284,411	12

Tax accrual used for 2001: 285,000

No offset to refund since it applies to a real estate tax bill which was not used to determine reimbursement

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BUCKINGHAM PAVILION COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0019836

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-36-201-009-0000	Long Term Care Property	$ 2,732.73	$ 2,732.73
2.	10-36-201-002-0000	Long Term Care Property	$ 4,372.11	$ 4,372.11
3.	10-36-201-006-0000	Long Term Care Property	$ 2,752.82	$ 2,752.82
4.	10-36-201-023-0000	Long Term Care Property	$ 122,916.68	$ 122,916.68
5.	10-36-201-008-0000	Long Term Care Property	$ 2,746.75	$ 2,746.75
6.	10-36-201-004-0000	Long Term Care Property	$ 99,008.77	$ 99,008.77
7.	10-36-201-001-0000	Long Term Care Property	$ 4,824.90	$ 4,824.90
8.	10-36-201-003-0000	Long Term Care Property	$ 42,151.62	$ 42,151.62
9.	10-36-201-007-0000	Long Term Care Property	$ 2,904.53	$ 2,904.53
10.			$	$
		TOTALS	$ 284,410.91	$ 284,410.91

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 67,656 B. General Construction Type: Exterior BRICK Frame STEEL & CONCRETI Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Building Site	42,086	1973 & 1978	$ 300,000	1
2					2
3	TOTALS	42,086		$ 300,000	3

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4				1975	$ 1,042,681	$ 26,067	35	$ 26,067	$	$ 695,293	4
5				1979	1,953,104	64,737	35	64,737		1,425,138	5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1975	334		20	-		-	9
10	Various			1976	1,973		20	-		-	10
11	Various			1980	3,208		20	-		-	11
12	Various			1981	2,800		20	-		-	12
13	Various			1983	8,923		20	261	261	3,956	13
14	Various			1984	2,865		20	143	143	143	14
15	Various			1985	19,459		20	973	973	973	15
16	Various			1989	68,100		20	3,406	3,406	13,802	16
17	Various			1990	9,307		20	465	465	465	17
18	Various			1992	8,110		20	406	406	406	18
19	Various			1996	3,565		20	178	178	178	19
20	Various			1997	32,746		20	1,637	1,637	1,637	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		-	-		-		-	68
69	Financial Statement Depreciation			8,321			(8,321)		69
70	TOTAL (lines 4 thru 69)		$ 3,157,175	$ 99,125		$ 98,273	$ (852)	$ 2,141,991	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,157,175	$ 99,125		$ 98,273	$ (852)	$ 2,141,991	1
2	PINE ROOFING, INC.	1998	24,500		20	1,225	1,225	3,921	2
3	G. DOLGIN-WALLCOVERG	1998			20				3
4	FRED SADOK-LABOR WLP	1998	984		20	49	49	151	4
5	HI GRADE-WALLPAPER	1998	2,453		20	123	123	379	5
6	COMFORT TEMP-WTR HTR	1998	1,040		20	52	52	160	6
7	CMFRT TEMP-AIR COIL	1998	889		20	44	44	136	7
8	CMFRT TEMP-HVAC SRV	1998	2,405		20	120	120	370	8
9	S. ELECT-CNTRL BXES	1998	3,240		20	162	162	648	9
10	WEATH TEMP-FIRE DMPR	1998			20				10
11	S. ELECT-DOOR HLDR	1998	1,021		20	51	51	204	11
12	REL. ELEV-DOOR RESTR	1998	4,200		20	210	210	718	12
13	S. ELEC-ELEC SGNL HR	1998	3,675		20	184	184	736	13
14	G. DOLGIN CO-WALLPR	1998	3,000		20	150	150	475	14
15	ECONOCARE-CRASHRAIL	1998	3,906		20	195	195	601	15
16	COM TEMP SYS-FIRE DM	1998	23,803		20	1,190	1,190	4,165	16
17	COM TEMP SYS-FIRE DM	1998	1,205		20	60	60	210	17
18	COM TEMP SYS-FIRE DM	1998	1,442		20	72	72	252	18
19	COM TEMP SYS-FIRE DA	1998	1,047		20	52	52	182	19
20	COM TEMP SYS-FIRE DM	1998	644		20	32	32	109	20
21	SHERWIN WILL-WLLPAPR	1998	1,769		20	88	88	293	21
22	FRED SADOK-LBR WLLPR	1998	2,846		20	142	142	462	22
23	SHERWIN WILL-WALLPR	1998	1,507		20	75	75	244	23
24	FRED SADOK-LABOR WPR	1998	1,296		20	65	65	206	24
25	FRED SADOK-LABOR WLP	1998	2,184		20	109	109	336	25
26	FRED SADOK-LABOR WLP	1998	1,452		20	73	73	225	26
27	HI-GRADE-WALLPAPER	1998	4,026		20	201	201	653	27
28	HI-GRADE-WALLPAPER	1998	4,143		20	207	207	673	28
29	HI GRADE-WALLPAPER	1998	595		20	30	30	98	29
30	HI GRADE-WALLPAPER	1998	893		20	45	45	146	30
31	HI GRADE-WALLPAPER	1998	555		20	28	28	91	31
32	HI GRADE-WALLPAPER	1998	5,987		20	299	299	972	32
33	HI GRADE-WALLPAPER	1998	363		20	18	18	57	33
34	TOTAL (lines 1 thru 33)		$ 3,264,245	$ 99,125		$ 103,624	$ 4,499	$ 2,159,864	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,264,245	$ 99,125		$ 103,624	$ 4,499	$ 2,159,864	1
2	HI GRADE-WALLPAPER	1998	1,730		20	87	87	276	2
3	HI GRADE-WALLPAPER	1998	3,974		20	199	199	630	3
4	WALLPAPER	1998	5,200		20	260	260	260	4
5	S.ELEC-ALARM SYSTEM	1999	2,392		20	120	120	320	5
6	ECONOCARE-BUMPERS RE	1999	4,104		20	205	205	564	6
7	RELIANCE-NEW CYLINDE	1999	21,010		20	1,051	1,051	2,540	7
8	ECONOCARE-CARPETING	1999	9,715		20	486	486	1,377	8
9	WEATH.TEMP-SPACE HTG	1999	47,812		20	2,391	2,391	5,181	9
10	S.ELECTRONIC-RUN COM	1999	1,726		20	86	86	179	10
11	FRED SADOK-WALLPAPER	1999	1,386		20	69	69	207	11
12	FRED SADOK-WALLPAPER	1999	2,040		20	102	102	306	12
13	G.DOGLIN CO-WALLPAPE	1999	7,300		20	365	365	1,065	13
14	FRED SADOK-WALLPAPER	1999	1,572		20	79	79	230	14
15	FRED SADOK-WALLPAPER	1999	2,438		20	122	122	356	15
16	FRED SADOK-WALLPAPER	1999	2,244		20	112	112	327	16
17	G.DOGLIN CO-WALLPAPE	1999	4,000		20	200	200	583	17
18	G.DOGLIN CO-WALLPAPE	1999	5,690		20	285	285	808	18
19	ECONOCARE-PAINT	1999	2,062		20	103	103	300	19
20	FRED SADEK-WALLPAPER	1999	1,728		20	86	86	244	20
21	FRED SADOK-PAINTING	1999	1,441		20	72	72	204	21
22	FRED SADOK-PAINTING	1999	1,400		20	70	70	193	22
23	SHELDON WALDMAN-WALL	1999			20				23
24	SHELDON WALDMAN-WALL	1999	3,480		20	174	174	441	24
25	ECONOCARE-WALLPAPER	1999	2,899		20	145	145	326	25
26	CUMMINS-HVAC SERV	1999	2,212		20	111	111	333	26
27	COMFORT-HVAC SERV	1999	3,151		20	158	158	448	27
28	COMFORT-HVAC SERV	1999	1,552		20	78	78	208	28
29	COMFORT-HVAC SERV	1999	1,774		20	89	89	237	29
30	DRAPERIES	1999	35,465		20	1,773	1,773	1,773	30
31	WALLPAPER	1999	6,500		20	325	325	325	31
32	ECONOCARE-INST.DRAPE	1999	4,494		20	225	225	1,011	32
33	WEATHER TEMP-SPACE H	2000	5,890		20	295	295	786	33
34	TOTAL (lines 1 thru 33)		$ 3,462,626	$ 99,125		$ 113,547	$ 14,422	$ 2,181,902	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,462,626	$ 99,125		$ 113,547	$ 14,422	$ 2,181,902	1
2	PAINTING	2000	2,094		20	105	105	105	2
3	WALLPAPER	2000	1,390		20	70	70	70	3
4	HEATING SYSTEM	2000	5,414		20	271	271	271	4
5	ROOM PUMP	2000	3,086		20	154	154	154	5
6	FREEZER REP	2000	1,221		20	61	61	61	6
7	FIRE ALARM INSTALL	2001	1,843		20	77	77	77	7
8	ACM ELEVATOR-MAJOR I	2001	8,690		20	254	254	254	8
9	FRONT ENTRANCE REMODELING	2001	151,000		20	629	629	629	9
10	WEATHER TEMP	2001	4,900		20	61	61	61	10
11	FRONT ENTRANCE REMODELING	2001	14,438		20	60	60	60	11
12	S.ELECTRONICS	2001	1,620		20	20	20	20	12
13	SPRINKLER SYSTEM	2001	2,140		20	9	9	9	13
14	WALK IN COOLER	2001	1,176		20	30	30	30	14
15	SPRINKLER SYSTEM	2001	1,968		20	49	49	49	15
16	SMOKE DETECTOR	2001	914		20	31	31	31	16
17	HOT WATER SUPPLY LINE	2001	1,221		20	61	61	61	17
18	BOUNDRY SURVEY	2001	800		20	20	20	20	18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,666,541	$ 99,125		$ 115,509	$ 16,384	$ 2,183,864	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,666,541	$ 99,125		$ 115,509	$ 16,384	$ 2,183,864	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,666,541	$ 99,125		$ 115,509	$ 16,384	$ 2,183,864	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 3,666,541	$ 99,125		$ 115,509	$ 16,384	$ 2,183,864	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,666,541	$ 99,125		$ 115,509	$ 16,384	$ 2,183,864	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 3,666,541	$ 99,125		$ 115,509	$ 16,384	$ 2,183,864	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,666,541	$ 99,125		$ 115,509	$ 16,384	$ 2,183,864	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 3,666,541	$ 99,125		$ 115,509	$ 16,384	$ 2,183,864	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,666,541	$ 99,125		$ 115,509	$ 16,384	$ 2,183,864	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 3,666,541	$ 99,125		$ 115,509	$ 16,384	$ 2,183,864	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,666,541	$ 99,125		$ 115,509	$ 16,384	$ 2,183,864	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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52									52
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57									57
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59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$	$		$	$	$	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 27,769	$ 34,237	$ 4,397	$ (29,840)	10	$ 11,634	71
72	Current Year Purchases	27,000		450	450	10	450	72
73	Fully Depreciated Assets	486,749				10	486,749	73
74								74
75	TOTALS	$ 541,518	$ 34,237	$ 4,847	$ (29,390)		$ 498,833	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	1995 FORD TAURUS	1994	$ 20,158	$	$	$	5	$ 20,158	76
77										77
78										78
79										79
80	TOTALS			$ 20,158	$	$	$		$ 20,158	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,528,217	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 133,362	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 120,356	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (13,006)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,702,855	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 1,176 Description: LAUNDRY MACHINES: $1,176
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	1999 ACURA	$ 669	$ 6,447	17
18					18
19					19
20					20
21	TOTAL		$ 669	$ 6,447	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 80

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies	9,398	3,446		12,844
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$ 9,398	$ 3,446	$	$ 12,844
10	SUM OF line 9, col. 1 and 2 (e)	$ 12,844			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	41
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	30
2. From other facilities (f)	
TOTAL TRAINED	71

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 24,860	$		$ 24,860	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			597			597	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	27,250		21,431			48,681	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				151,876		151,876	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):						52,009		52,009	13
14	TOTAL			$ 27,250		$ 46,888	$ 203,885		$ 278,023	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 5,547	$ 6,156	1
2	Cash-Patient Deposits	29,225	29,225	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,074,502	1,074,502	3
4	Supply Inventory (priced at)	3,072	3,072	4
5	Short-Term Investments			5
6	Prepaid Insurance	107,850	107,850	6
7	Other Prepaid Expenses	3,423	3,423	7
8	Accounts Receivable (owners or related parties)	363	363	8
9	Other(specify): See supplemental schedule	29,406	29,406	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,253,388	$ 1,253,997	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		300,000	13
14	Buildings, at Historical Cost		1,042,681	14
15	Leasehold Improvements, at Historical Cost	395,561	2,348,665	15
16	Equipment, at Historical Cost	604,168	604,168	16
17	Accumulated Depreciation (book methods)	(621,140)	(2,741,571)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	5,050	5,050	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 383,639	$ 1,558,993	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,637,027	$ 2,812,990	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 995,985	$ 995,985	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	31,948	31,948	28
29	Short-Term Notes Payable	53,130	53,130	29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	18,047	18,047	31
32	Accrued Real Estate Taxes(Sch.IX-B)	285,000	285,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	9,285	9,285	35
	Other Current Liabilities(specify):			
36	See supplemental schedule	194,964	194,964	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,588,359	$ 1,588,359	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,588,359	$ 1,588,359	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 48,668	$ 1,224,631	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,637,027	$ 2,812,990	48

*(See instructions.)

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 279,733	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 279,733	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	568,935	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(800,000)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (231,065)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 48,668	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,307,073	1
2	Discounts and Allowances for all Levels	(133,187)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,173,886	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	85,954	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 85,954	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	16,294	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	153,900	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	22,734	19
20	Radiology and X-Ray	2,295	20
21	Other Medical Services	85,305	21
22	Laundry	3,909	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 284,437	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	346	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 346	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	4,464	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,464	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,549,087	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	760,056	31
32	Health Care	1,553,228	32
33	General Administration	1,184,984	33
	B. Capital Expense		
34	Ownership	1,039,515	34
	C. Ancillary Expense		
35	Special Cost Centers	307,136	35
36	Provider Participation Fee	135,233	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,980,152	40
41	**Income before Income Taxes (line 30 minus line 40)****	568,935	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 568,935	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 84,936	$ 40.83	1
2	Assistant Director of Nursing	1,744	1,904	51,200	26.89	2
3	Registered Nurses	23,207	24,758	529,964	21.41	3
4	Licensed Practical Nurses	6,613	7,121	117,255	16.47	4
5	Nurse Aides & Orderlies	66,305	71,063	496,396	6.99	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	564	564	27,250	48.32	7
8	Rehab/Therapy Aides	4,128	4,648	51,489	11.08	8
9	Activity Director					9
10	Activity Assistants	6,211	6,547	64,209	9.81	10
11	Social Service Workers	1,960	1,960	37,056	18.91	11
12	Dietician					12
13	Food Service Supervisor	2,197	2,453	31,532	12.85	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,420	18,620	121,364	6.52	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	16,053	17,384	123,384	7.10	18
19	Laundry	7,623	8,087	50,215	6.21	19
20	Administrator	2,304	2,304	52,399	22.74	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,569	9,038	192,906	21.34	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	810	753	11,059	14.69	33
34	TOTAL (lines 1 - 33)	167,788	179,284	$ 2,042,614 *	$ 11.39	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	154	$ 7,243	01-03	35
36	Medical Director	monthly	7,800	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	73	2,446	10-03	38
39	Pharmacist Consultant	monthly	7,368	10-03	39
40	Physical Therapy Consultant	13	653	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	5	152	11-03	44
45	Social Service Consultant	91	4,548	12-03	45
46	Other(specify)				46
47	Wound Care Consultant	monthly	2,100	10-03	47
48	MDS Consultant	monthly	2,185	10-03	48
49	TOTAL (lines 35 - 48)	336	$ 34,495		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	125	$ 4,152	10-03	50
51	Licensed Practical Nurses	312	8,160	10-03	51
52	Nurse Aides	1,531	24,018	10-03	52
53	TOTAL (lines 50 - 52)	1,968	$ 36,330		53

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Margaret Stern	Administrator	0	$ 52,399
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 52,399

B. Administrative - Other

Description	Amount
Sheldon Stern - Management Fees	$ 282,602
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 282,602

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 40,281
Personnel Planners	Unemployment Consult	1,000
ADP	Data Processing	6,124
Senior Living Systems	Computer Services	4,795
Backup & More	Computer Services	925
Computer Services, LTD	Computer Services	1,832
See Attached	Legal	14,984
Lawrence D. Merzel	Real Estate Appraisal	500
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 70,441

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 37,291
Unemployment Compensation Insurance	20,561
FICA Taxes	156,260
Employee Health Insurance	53,299
Employee Meals	23,871
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	2,510
TOTAL (agree to Schedule V, line 22, col.8)	$ 293,792

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	14,128
Health Care Worker Background Check	1,026
(Indicate # of checks performed 91)	
licenses	7,124
yellow page ads	42,518
advertising & promotion	32,359
Less: Public Relations Expense	
Non-allowable advertising	(32,359)
Yellow page advertising	(42,518)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,678

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,495
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,495

**See instructions.

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	na		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number BUCKINGHAM PAVILION # 0019836 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? no

(2) Are there any dues to nursing home associations included on the cost report? no
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 10 yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 23,977 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES x NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 135,233
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 23,871 Has any meal income been offset against related costs? no Indicate the amount. $ n/a

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 100%ln14
d. Have vehicle usage logs been maintained? no
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? no
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees